

No. 2  
9-4-41  
17-39  
X29484

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED AUG 11 1942

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24878

Registration District No. 243

Primary Registration District No. 4364

Registrar's No. 34

1. PLACE OF DEATH:

(a) County Newton

(b) City or town Stella

(c) Name of hospital or institution: Stella Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 Days  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Newton

(c) City or town Wentworth Mo.  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Opal Elizabeth Horner

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August, day 2  
year 1942 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from July 30<sup>th</sup> 1942 to August 2<sup>nd</sup> 1942  
that I last saw her alive on August 2 1942  
and that death occurred on the date and hour stated above.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced... Single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
(Day) (Year)

Immediate cause of death 3<sup>rd</sup> degree Burns - 4/5 of the body

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

8. AGE: Years 37 Months 4 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Wentworth Mo. (City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

Underline the cause to which death should be charged statistically.

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Chas. Horner

13. Birthplace Wairas (City, town, or county) (State or foreign country)

14. Maiden name Bridget J. Jacobs

15. Birthplace Sandee Mo. (City, town, or county) (State or foreign country)

16. (a) Informant C.P. Horner

(b) Address St. Louis, Mo.

17. (a) Burial (b) Date thereof 8 4 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sargis Mo.

18. (a) Signature of funeral director W.D. Koon

(b) Address Cassville, Mo.

19. (a) Aug 5 1942 (b) Dana Herster  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Suicide

(b) Date of occurrence July 30<sup>th</sup> 1942

(c) Where did injury occur Wentworth, Newton, Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
About home, back yard  
(Specify type of place)

While at work \_\_\_\_\_ (e) Means of injury ( )

23. Signature C. Cardwell M.D. (M.D. or other) \_\_\_\_\_  
Address Stella, Mo. Date signed 8/2/42

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1181

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 6,

District File Number 842-1065-

Date Filed AUG 10 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*John E. Myers*  
Licensed Embalmer No. 3220  
P. O. Address Cassville, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 24878

Registration District No. 243

Primary Registration District No. 4364

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Newton  
(b) City or town Stella  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Stella Hosp.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Opal Elizabeth Horner  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased mar 24  
(Month) (Day) (Year)

8. AGE: Years 37 Months 4 Days 5  
(If less than one day \_\_\_\_\_ min.)

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name \_\_\_\_\_

15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day 10 Year 1960 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Stems self inflicted  
abnormal mind  
became angry and  
set fire to clothing  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external cause, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature Cardwell (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

WRITE PLAINLY - USE UNFADING BLACK INK - MAKE A PERMANENT RECORD

MOTHER FATHER

SUPPLEMENTARY

